

Balanced By Fitness
Personal Training Program
Health Status Questionnaire

CLIENT INFORMATION

_____ Name		_____ Date	PT Package_____
_____ Date of Birth	_____ Age	_____ Gender	
_____ Street Address		_____ Primary Phone Number	
_____ City, State, Zip		_____ Secondary Phone Number	
_____ Email			
_____ Emergency Contact /Relationship		_____ Emergency Contact Phone	
_____ Physician		_____ Physician Number	

How did you hear about our personal training program?

Brochure Website
 Staff Other (Please Specify): _____

MEDICAL AND HEALTH STATUS QUESTIONNAIRE

Throughout this questionnaire, a number of questions regarding your physical health and activity lifestyle are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. Place a check in each space to the left of the question to respond "Yes". Leave question blank if answer is "No". All answers will be treated in a confidential manner.

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Medical Screening

- Do you have any personal history of heart disease (coronary or atherosclerotic disease)?
- Any personal history of diabetes or other metabolic disease (thyroid, renal, liver)?
- Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
- Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?
- Any unaccustomed shortness of breath (possibly during exercise)?
- Have you had any difficulty breathing while standing or sudden breathing problems at night?
- Rapid throbbing or fluttering of the heart?
- Have you experienced severe pain in leg muscles during walking?
- Do you suffer from ankle edema (swelling of the ankles)?
- Do you have a known heart murmur?
- Has your serum cholesterol been measured at greater than 200 mg/dl?
- Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?
- Are you a cigarette smoker?
- Would you characterize your lifestyle as "sedentary"?
- Have you had a high fasting blood glucose level on 2 or more occasions (≥ 110 mg/dl)?
- Are you 20% or more overweight or have you been told your "BMI" was greater than 30?
- Have you been assessed as hypertensive on at least 2 occasions (systolic > 140 mmHg or diastolic > 90 mmHg)?
- Do you have any family history of cardiac or pulmonary disease prior to age 55?

PAR-Q MEDICAL STATUS

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. If you are planning to become much more physically active than you are now, start by answering the seven questions below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each question honestly. Place a check in each space to the left of the question to respond "Yes". Leave question blank if answer is "No". All answers will be treated in a confidential manner (ACSM, 2007).

- Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor?
- Do you feel pain in your chest when you do physical activity?
- In the past month, have you had chest pain when you were not doing physical activity?
- Do you lose your balance because of dizziness or do you ever lose consciousness?
- Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
- Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- Do you know of any other reason why you should not do physical activity?

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If you answered YES to one or more questions, talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES. You may be able to do any activity you want -- as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk to your doctor about the kinds of activities you wish to participate in and follow his/her advice.

If you answered NO to all questions, you can be reasonably sure that you can:

- ✓ Start becoming much more physically active -- begin slowly and build up gradually. This is the safest and easiest way to go.
- ✓ Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

Delay becoming much more active:

- ✓ If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- ✓ If you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above PAR-Q questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity (ACSM, 2006).

“I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.”

Initials: _____

Signature of Parent/Guardian (For participants ≤ 17 years)

Medical History

- Are you currently being treated for high blood pressure?
-If so, do you know your average blood pressure? _____/_____

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Please check any and/or all conditions/diagnoses that apply:

<input type="checkbox"/> Abnormal ECG	<input type="checkbox"/> Limited Range of motion	<input type="checkbox"/> Stroke
<input type="checkbox"/> Abnormal Chest X-Ray	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Chronic Headaches or Migraines
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Swollen or Painful Joints	<input type="checkbox"/> Persistent Fatigue
<input type="checkbox"/> Asthma	<input type="checkbox"/> Foot problems	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Knee problems	<input type="checkbox"/> Hernia
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Back problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Other Lung problems:	<input type="checkbox"/> Shoulder problems	<input type="checkbox"/> Currently Pregnant
	<input type="checkbox"/> Recently broken Bones:	

Has a doctor imposed any physical restrictions if above box(s) have been checked? If so, please explain:

Family History

Has any family member suffered from any of the following? (Please check all that apply):

<input type="checkbox"/> Heart attack or Heart surgery before age 55	<input type="checkbox"/> Obesity
<input type="checkbox"/> Congenital Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Musculoskeletal Problems
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cancer prior to age 60
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke prior to age 50

Medications

Please select medications that you are currently using:

<input type="checkbox"/> Alpha Blockers	<input type="checkbox"/> Vasodilators
<input type="checkbox"/> Beta Blockers	<input type="checkbox"/> Other Cardiovascular
<input type="checkbox"/> Calcium Channel blockers	<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Diuretics	<input type="checkbox"/> NSAIDS/Anti-Inflammatories (Motrin, Advil)
<input type="checkbox"/> Diabetes/Insulin	<input type="checkbox"/> Other Drugs (record below)

Please list specific medications that you are currently taking/ or were not in the chart:

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Lifestyles

- Are you a cigarette/cigar smoker? If so, how many per day do you smoke?
- Previously a cigarette smoker? If so, when did you quit?
- Do you/did you smoke (Circle all that apply): Cigarettes Cigars Pipes

Please Rate your daily stress level (select one):

- Low
- Moderate
- High-but not unmanageable
- High-sometimes difficult to manage
- High-too difficult/unmanageable
- Do you drink alcoholic beverages?

How many units of alcohol do you consume per week: _____ (See chart below)

Alcohol Units Table

Type of Drink	Units
1/2 pint of beer	1
1 glass of wine	1
1 pub measure of liquors (Gin, Vodka etc)	1
1 can of beer	1.5
1 bottle of strong lager	2.5
1 can of strong lager	4
1 bottle of wine	7
1 liter bottle of wine	10
1 bottle liquor (Sherry,etc)	14
1 bottle of spirits	30

Other

Please indicate any other medical conditions or restrictions you may have that have not been listed above. Be as accurate as possible.

- Check here if any of the above information is pertinent to our personal trainers' understandings and expectations for your exercise prescriptions.

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HEALTH AND FITNESS GOALS

Below are some questions that will help our personal trainers' as well as you learning more about your health and fitness goals. In completing these questions, we then ask that you write three goals that you can commit too that will aid yourself in improving your health and fitness. Should you have any questions, feel free to consult with your trainer.

Please indicate your personal health and fitness related goals: (Check all that apply)

<input type="checkbox"/> Aerobic Fitness	<input type="checkbox"/> Feel better	<input type="checkbox"/> Improve Flexibility	<input type="checkbox"/> General Fitness
<input type="checkbox"/> Improve Diet	<input type="checkbox"/> Injury Rehab	<input type="checkbox"/> Look Better	<input type="checkbox"/> Lose Weight
<input type="checkbox"/> Lower my Cholesterol	<input type="checkbox"/> Muscular Size	<input type="checkbox"/> Muscular Strength	<input type="checkbox"/> Reduce Back Pain
<input type="checkbox"/> Reduce Stress	<input type="checkbox"/> Sports Specific	<input type="checkbox"/> Stop Smoking	<input type="checkbox"/> Other

If other was checked, please explain:

Please tell us more about yourself in regards to your exercise history and goals:

What is your exercise history?

What health improvements do you need/want?

What are your activity preferences?

What barriers do you anticipate holding you back?

What is your motivation level? High Medium Low

What is your confidence level? High Medium Low

Is there someone that will be able to back you up on your exercise goals? If so, Who?

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Please record below three specific goals that you are willing to commit too. For example, one goal might be, "to arrive on time to every session of exercise you have scheduled". The goals below should be challenges to you but they also need to be realistic and achievable. When you have finished, please sign this sheet to indicate your personal commitment to your goals.

Goal #1: _____

Goal #2: _____

Goal #3: _____

Signature: _____

FITNESS INTERESTS

Recent Exercise schedule:

- ✓ Average hours per week exercising? _____
- ✓ Average length of a work-out? _____ (minutes)
- ✓ Intensity of a work-out (Scale of 1-10: 1 being easy-10 hardest) _____
- ✓ How long have you worked out on a regular basis? _____ (years)

A typical week of exercising consists of what exercises? (Check all that apply and how long you work in minutes):

- Running/Jogging: _____
- Walking: _____
- Biking/Spinning: _____
- Stair Climbing: _____
- Weight Training: _____
- Aerobics : _____
- Swimming: _____
- Racquet Ball: _____
- Yoga/Pilates: _____
- Other: (Please Specify) _____

What activities interest or are preferred by you?

<input type="checkbox"/> Aerobic Classes	<input type="checkbox"/> Free Weights	<input type="checkbox"/> Golf
<input type="checkbox"/> Group Activities	<input type="checkbox"/> Martial Arts	<input type="checkbox"/> Spinning (Indoor)
<input type="checkbox"/> Cycling (outdoor)	<input type="checkbox"/> Running	<input type="checkbox"/> Tennis
<input type="checkbox"/> Step Aerobics	<input type="checkbox"/> Swimming	<input type="checkbox"/> Other
<input type="checkbox"/> Walking		

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INFORMED CONSENT

- I hereby consent that I voluntarily engage in physical fitness training exercises that are recommended to me in order to improve my over fitness and well being. I understand that I may have to undergo a series of Health and Physical Fitness assessment tests designed to aid my understanding of my own health and physical fitness and/or obtain physician consent to exercise. I understand that during these assessment tests I will be given precise instructions on what I should be doing.
- If I am taking any prescribed medications, I have already informed my trainer and/or will inform them of any changes that might occur during our training sessions.
- I understand that being in the program, I will voluntarily complete each exercise to the best of my ability or until such symptoms such as fatigue, shortness of breath, chest discomfort, or similar symptoms occur. At any point during the session I understand that it is my complete right to stop exercise, and then inform my trainer of what is going on.
- I understand that during the performance of my personal fitness training session, physical touching and/or positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, and to ensure that I am using proper technique and body alignment. I consent to physical contact for these reasons.
- I understand that this exercise program may benefit my physical fitness or general overall health, and if I follow the programs' instructions, my exercise capacity and fitness level may improve after time. However, this program cannot guarantee any particular level of improvement. I understand that involvement in the personal training fitness sessions will allow me to learn proper techniques to perform exercises, use fitness equipment, and regulate physical effort.
- I understand that the information provided will be kept confidential and will not be released or revealed to any person without a written consent.

Participant (Please Print)

Date

Phone

Participant (Signature)

Personal Trainer

Date

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PAYMENT AGREEMENT

Here at the BBF strive to bring you only the very best in personal training. All of our trainers are certified by an accredited program which represents the golden standard in personal training. To ensure that we can continue to bring you top quality personal training at an affordable price, it is required that we collect payment in advance. By making your payment when turning in your Health Status Questionnaire, you will be guaranteed a reserved time slot with one of our personal trainers. If for some reason you will be unable to make your scheduled appointment, we do require at least 4 hours prior notification so that we may open the time slot for someone else. If a prior notification is not administered, forfeiting of one training session will occur.

Similarly it is imperative to start the session no later than 15 minutes past the originally scheduled time so as not to compromise the quality of the session. Therefore please be sure to allow time before your session to change clothes, etc. Please read and sign the section below and thank you for your business.

I _____, understand that to secure a personal trainer for a scheduled time slot I must make all payments no later than 24 hours in advance of the scheduled appointment. I also understand that if I fail to give at least 4 hours of notice prior to any cancellation that I will be charged the full amount for a regular training session. Similarly I also understand that if I am more than 15 minutes late, the session will be cancelled and I will be charged the full amount for the session.

I _____, also understand that by purchasing a personal training package all sessions will expire 6 months from purchase date. No refunds will be administered to any training sessions that are booked with trainer or any sessions you do not wish to use.

I, _____, understand that I am paying for this personal training package in full and understand all said information above. If I do not understand, I will ask that it be explained to me as best as possible.

Participant (Signature)

Date